MILLIMAN CLIENT REPORT

Behavioral Health Encounter Data Quality Methodology and Instructions – SFY 2023 Period 2

State of Michigan, Department of Health and Human Services

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I. Background and Executive Summary

Milliman, Inc. (Milliman) has been retained by the State of Michigan, Department of Health and Human Services (MDHHS) to provide actuarial and consulting services related to the Medicaid behavioral health (BH) program. We were requested to assist in the development of a reporting template for the Encounter Quality Initiative (EQI), which includes encounter and financial monitoring and reconciliation reports. This process will collect financial, eligibility, and encounter information from each of the community mental health service programs (CMHSPs) and prepaid inpatient health plans (PIHPs). The financial information being requested includes revenue (PIHP only), service level utilization and net cost (UNC), non-benefit expenses, and other expenses. The *Service UNC* tab will reflect internally maintained CMHSP and PIHP data and will facilitate the comparison of data in the encounter data warehouse. The cost information reported in the EQI should reflect total costs attributable to the corresponding programs and populations included within the template. The CMHSP and PIHP reported information should include all Medicaid and non-Medicaid behavioral health services provided by the CMHSPs and other mental health, developmental disabilities, and substance abuse contracted network providers. The one exception is non-Medicaid SUD services provided outside of the CCBHC demonstration, which are not required to be reported in the EQI for SFY 2023 Period 2. If the PIHP or CMHSP chooses to report SUD non-managed care services in the EQI for SFY 2023 Period 2, it should be added to the *Notes* tab that they are doing so.

The following provide the goals of the behavioral health EQI process.

- to collect high-level information (including but not limited to revenue, membership, and total actual costs) to monitor the managed care program financial status and non-Medicaid expenses
- to provide a comparison of the encounter data to the CMHSP and PIHP reported information so that all stakeholders can identify and address any encounter data quality concerns on an ongoing basis for both the Medicaid managed care and non-managed care populations
- to consolidate and refine several of the historical reporting templates into one comprehensive template
- to streamline processes to enable more frequent and timely reporting

For the purposes of this analysis, each CMHSP and PIHP will submit the information as requested above to MDHHS. Figure 1 includes the timing for each of the steps in the SFY 2023 Period 2 behavioral health EQI process. Encounters will be pulled for purposes of the EQI comparison using the August 3rd data extract, with future extracts being used for purposes of capitation rate setting.

FIGURE 1: SFY 2023 PERIOD 2 BH EQI SCHEDULE

BH EQI PROCESS STEP	DEADLINE
Template provided to PIHPs and CMHSPs	7/1/2023
Milliman Detailed Encounter Provided by DHHS to PIHPs	8/3 extract by 8/18/2023
Detailed Encounter Corrections Due	9/1/2023
Optum Data to Milliman	9/3/2023
PIHPs Submit Reports to DHHS	10/2/2023
Milliman Delivers Utilization Comparison to PIHPs via DRIVE	11/1/2023
Response to observations due to DHHS, explaining variances/questions/or corrective action plans as appropriate	11/30/2023

To aid in the validation of encounter data, we are providing access to reported information via the DRIVE™ Comparison Dashboard for PIHPs who pay a nominal license fee. This Comparison Dashboard is a web-based application that is hosted by Milliman where MDHHS and the PIHPs can access the reports like the excel reports provided for encounter data quality. It provides a dynamic view that allows users to review the PIHP and CMHSP reported information in multiple ways.

The EQI Data Collection Tool provides a pre-populated template for each CMHSP and PIHP to summarize and submit their understanding of the Medicaid utilization and expenditures incurred for providing behavioral health services. The PIHP template is limited to the populations eligible for Michigan's Medicaid behavioral health managed care program and the other-funded (e.g., via grants) services. The CMHSP template includes the Medicaid

behavioral health, non-managed care General Fund, and other-funded populations and services. The dual CMHSP/PIHP template includes all populations included in either the PIHP or CMHSP templates.

For purposes of SFY 2023, non-managed care SUD services provided at a CCBHC demonstration site will be required within EQI reporting. All other non-managed care SUD (i.e., Substance Abuse Prevention and Treatment Block Grant, SUD General Fund, and other non-managed care SUD funds administered in EGrAMS that are reported to the state for the section 904 legislative report) units and costs reporting are consistent with prior periods and are not required within the EQI but can be included. If the PIHP or CMHSP chooses to report SUD non-managed care services in the EQI for SFY 2023 Period 2, it should be added to the *Notes* tab that they are doing so. We will be working with the EQI Workgroup to determine if and how non-Medicaid SUD units and costs should be included within subsequent SFY 2023 EQI reporting.

PIHPs are expected to report encounters for services for which providers were paid (paid claims), third party reimbursed, and/or any services provided directly by the Contractor. Encounter data is collected and reported for every individual for which a claim was adjudicated, or service rendered during the month by the Contractor (directly or via contract) regardless of payment source or funding stream. (MDHHS/PIHP contract 3.1 Project Management Reporting section, Encounter Data Reporting; MDHHS/CMHSP contract C6.5.1.1). MDHHS provides additional guidance for CMHSP direct-run services that the scope of encounter reporting includes both encounters for which third party covers 100% of the cost and as well as encounters for which non-MDHHS dollars pay for the service. Currently this guidance does not apply to providers external to the PIHP or CMHSP as MDHHS recognizes that collecting information from external providers when the CMHSP or PIHP has $0 liability to pay may be unduly burdensome.

The EQI Data Collection Tool includes the following tabs to collect cumulative information for the October 2022 to May 2023 time period using claims submitted to MDHHS as of July 31, 2023. ***Due to the attestation provided at the entity level, each CMHSP and PIHP will be responsible for submitting their respective report to MDHHS at qmpmeasures@michigan.gov.***

Each regional PIHP will be responsible for providing MDHHS the aggregated report for their PIHP, including the Medicaid utilization and expenditures from the CMHSPs in their catchment area. Each CMHSP and PIHP should submit their information in a single Excel workbook consistent with the way they received the template, which includes the following worksheets.

- Attestation
- Service Code Set
- Eligibility and Revenue (Regional PIHP Only)
- Service UNC
- Service Cat UNC – PIHP (Regional PIHP Only)
- Service Cat UNC – CMHSP
- Elig Source Summary
- Final DR Clinical CC Summ (CMHSP and Dual CMHSP/PIHP Only)
- COB Summary
- Non-Benefit Expenses
- Other Expenses
- Spend-Down Summary
- Financial Reconciliation
- TIN Listings
- Notes

The Medicaid populations included in the EQI reporting process are consistent with those covered under the Medicaid BH managed care program, including the disabled, aged, and blind (DAB), temporary assistance for needy families (TANF), Healthy Michigan Plan (HMP), 1915(c) habilitation supports waiver (HSW), 1915(c) serious emotional disturbances (SED) waiver, and the 1915(c) children's waiver program (CWP).

Lastly, the templates include a stratification for non-managed care beneficiaries receiving services covered via state *General Fund* as well as all *Other* fund sources and non-managed care services for Medicaid enrollees.

This report contains the instructions to assist the CMHSPs and PIHPs in completing the template with eligibility, revenue, expense, and utilization information for the October 1, 2022 to May 31, 2023 (SFY 2023 Period 2) behavioral health EQI process. This report also includes the methodology that we will utilize to map encounter claims to specific PIHPs, programs, and populations. The encounter data is submitted by each PIHP into MDHHS' data warehouse, which is then provided to Milliman monthly.

The *Service Code Set* tab in the EQI Data Collection Tool provides a listing of each service included in Michigan's behavioral health code chart, including the description, reporting unit type, category of service, whether it is included in the Medicaid managed care program, and the corresponding Medicaid authority. The *Service Code Set* tab was developed using the *SFY 2023 Behavioral Health Code Charts and Provider Qualifications.xlsx* on the MDHHS web site[1].

Coordination with the Standard Cost Allocation Workgroup

The EQI template and instructions align with MDHHS' long-term goals for CMHSP and PIHP reporting. Concurrently with the EQI reporting, the Community Mental Health Association of Michigan is sponsoring a Standard Cost Allocation (SCA) Workgroup, which includes participation from MDHHS and Milliman, to provide further guidance to the field regarding the EQI reporting requirement. It is our understanding that compliance with 42 CFR § 438.8 was difficult to implement for some entities during SFY 2022. One of the goals of this Standard Cost Allocation Workgroup that relates to the EQI reporting is the following:

Consistently and appropriately allocating administrative costs in compliance with 42 CFR § 438.8 to either CMHSP direct-run service provider administration, contracted provider administration, or managed care administrative expenses.

In SFY 2023, we anticipate that some CMHSPs and PIHPs will complete the EQI template using existing methodologies to allocate administrative costs while others have transitioned to using the SCA methodology. An input has been added to the *Attestation* tab to document whether the SCA methodology was followed to complete SFY 2023 EQI reporting.

Key template differences across entities

The EQI template generally collects similar information across all entities; however, there are some differences in the reporting template depending on whether the entity is a CMHSP, a regional PIHP, or a dual CMHSP and PIHP. The following provides the key differences in the template across these three entity types:

- Regional PIHP templates are entity-specific, but the only difference is the *Service Cat UNC – CMHSP* tab includes a reporting split to capture expenses from all the CMHSPs in their region. Services contracted through the PIHP and not the CMHSP should be entered in the *Service UNC* tab and the *Service Cat UNC – PIHP* tab.
    - Following validation of encounter data, Regional PIHPs are instructed to input the *Service Cat UNC – CMHSP* tab from each CMHSP template into the PIHPs *Service Cat UNC – CMHSP* tab.
    - The *Service UNC* tab of Regional PIHPs is limited to Services Contracted through the PIHP.
- CMHSP templates collect expense information for the Medicaid, General Fund, and Other funded beneficiaries.
- Dual CMHSP/PIHP templates are consistent with all other CMHSP templates.

[1]https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html

II. Master Eligibility File Logic

This section details the methodology for creating a master eligibility file to be used for purposes of data processing, merging with the encounter data, and populating the EQI template. Additionally, guidance is provided for the handling of the merge of eligibility and encounters, particularly, with respect to a member spending down assets and becoming Medicaid eligible.

Program and Population Logic

Most of the tabs included in the template request information to be separated for each program and population. To assign a given individual's eligibility, service utilization, and service cost to a program and population, we would request the CMHSPs and PIHPs use the capitation file (820 data feed) as priority to assign the Medicaid population attributed to your entity. Effective October 1, 2019, MDHHS began making payments for retroactive eligible beneficiaries for up to six months. We anticipate only a small number of individuals to be retroactively Medicaid eligible for a month more than six months following the month of eligibility. We request that the CMHSPs and PIHPs identify these retroactively eligible Medicaid beneficiaries without a capitation payment using the eligibility file (834 data feed). If a beneficiary is not Medicaid eligible using the 820 or 834 files, entities should check the 270/271 to determine if the beneficiary has Medicaid eligibility in another county. Non-managed care general fund and/or grant funded beneficiaries served by the CMHSPs/PIHPs are identified as not having Medicaid eligibility for a given month in the 820, 834, or 270/271 data feeds. If a beneficiary is included in the 820 file, but not the 834 file, we would request that the beneficiary still be included. Figure 2 below provides a list of the behavioral health managed care program codes used to identify the Medicaid program and corresponding populations in the capitation data as well as the qualifying benefit plans used for purposes of the eligibility file.

FIGURE 2: MEDICAID BEHAVIORAL HEALTH MANAGED CARE ENROLLEE IDENTIFICATION

POPULATION / POPULATION GROUP	CAPITATION DATA MANAGED CARE PROGRAM CODE	MEDICAID ELIGIBILITY BENEFIT PLAN
DAB/TANF Enrolled	0006	HAS_BENEFIT_BHMA_MHP
DAB/TANF Unenrolled	0005	HAS_BENEFIT_BHMA
HMP Enrolled	0008	HAS_BENEFIT_BHHMP_MHP
HMP Unenrolled	0007	HAS_BENEFIT_BHHMP
HSW	0045	HAS_BENEFIT_HSW_MC
CWP	0077	HAS_BENEFIT_CWP_MC
SED	0082	HAS_BENEFIT_SED_MC

Figure 3 provides the applicable qualifying eligibility program codes to identify the DAB population separately from the TANF population for purposes of EQI reporting splits required in SFY 2023.

FIGURE 3: ELIGIBILITY PROGRAM CODE MAPPING

POPULATION	ELIGIBILITY PROGRAM CODES
DAB	A, B, E, M, O, P, Q
TANF	C, F, L, N, T

Although the MI Health Link program enrollees are not separately identified in the EQI, this stratification will still be required for purposes of the financial status report (FSR). This identification can be found on the coordination of benefits (COB) loop of the 834 file. Additionally, the spend-down effective date and enrollees in a Medicaid health plan can also be found on the COB loop of the 834 file.

Reference A provides the crosswalk from the county of eligibility to the applicable CMHSP, PIHP, and region. The following provides additional information regarding the identification of individuals.

- Enrollees are attributed to a PIHP based on the capitation and Medicaid eligibility files based on the fields provided in Figure 4 below. This shows eligibility based on county of residence as well as the PIHP that received a capitation payment for the beneficiary. For the HSW population, the PIHP was previously assigned based on the waiver service authorization (WSA) file, which may have reflected a county different from the county of eligibility (i.e., the county of financial responsibility (COFR)). For SFY 2023 Period 2 and onward, the PIHP for the HSW population will be assigned using CONTRACTOR ID. This is consistent with all other

populations. Enrollees are attributed to a CMHSP for purposes of the EQI analysis based on the county of eligibility from the capitation data or Medicaid eligibility file for both waiver and non-waiver individuals.

- The COFR PIHP is anticipated to continue submitting encounters in SFY 2023 consistent with prior reporting periods. MDHHS is considering changes to this for future time periods to align the PIHP responsibility of submitting encounters and paying claims with the PIHP who is receiving the capitation payment.
- Encounters are assigned to the CMHSP/PIHP that submitted the encounter (identified by the originator plan ID). Encounters submitted by a PIHP for a member with a capitation payment to a different PIHP will be separately identifiable in future EQI data validation.

PIHP Identification

In the next section of this report, we have provided instructions for the creation of a master eligibility file to be used in aiding the PIHPs and CMHSPs with populating the EQI Template. Throughout the creation of the master eligibility file, the PIHPs and CMHSPs will be expected to utilize three separate data feeds in order to populate the necessary fields. Figure 4 outlines the data field used by Milliman for identifying PIHP for each of the applicable data feeds.

FIGURE 4: PIHP IDENTIFICATION

DATA FEED	FIELD USED TO IDENTIFY PIHP
820 capitation data feed	CONTRACTOR_ID
834 eligibility data feed	COUNTY (see Reference A for mapping)
270/271 eligibility data feed	N/A

Development of Master Eligibility File

To facilitate the creation of the program and population information on the eligibility and encounter data, we have developed methodology to create a master eligibility file, which is comprised of information from the following three data sources.

1. Capitation file (820 data feed)
2. Eligibility file (834 data feed)
3. Eligibility file (270/271 data feed)

Please note that MDHHS requests that CMHSPs and PIHPs only utilize the 270/271 eligibility file in cases where the CMHSP or PIHP is providing services to individuals that are not Medicaid eligible in a given month (based on the 820 and 834 files) in one of the counties in their geographic catchment area (this would include encounters for COFR individuals as well as other individuals served by CMHSPs outside of the county where the individual lives). The 270/271 eligibility file is only anticipated to be needed for less than 5% of the individuals' receiving services. If an individual is not Medicaid eligible in the 820, 834, or the 270/271 files, then they should be covered by the General Fund or Grants. Using the 270/271 data is considered a "last resort" option, as Milliman does not have access to the files, and therefore the 270/271 files will not be utilized in EQI reporting and reconciliation.

The following outlines the detailed instructions that should be used to create the master eligibility file for purposes of EQI reporting. The master eligibility file should be created by the PIHP only, and then shared with each CMHSP in their catchment area. CMHSPs should start with step 11, using the master eligibility file created by the PIHP.

1. Within the capitation file, condense a member's payments into a single record per month
    a. Have fields designating non-waiver/waiver payments and revenue separately.
    b. Non-waiver payments should include mental health state plan, mental health 1915(i), autism, and substance use disorder state plan payments.
    c. There should not be more than one 1915(c) Waiver payment, so we have only included one revenue column for those payments as well, with flags to indicate which Waiver the revenue is attributable to.
    d. Capitation file should now be unique by MemberID and month.
2. Create a unique listing of Member ID and incurred month for those who received a service (based on the from date of the claim). Merge this list of Member ID and incurred month against the 820 and 834 eligibility files to determine which member/month combinations have no corresponding Medicaid eligibility. Pull the 270/271 eligibility file for this list of Member IDs and incurred months where the beneficiary does not have Medicaid eligibility (i.e., is not identified in the PIHPs 820 and 834 files).

3. Assign program and population in capitation and eligibility (834 and 270/271) files based on codes noted in the previous section. Possible population values for the BH Managed Care program include DAB, TANF or HMP. If the eligibility file does not have an applicable BH Managed Care program and population, the program should be assigned to Non-Managed Care and the population should be set to General Fund.
    a. In the eligibility file, one record per member per month will contain the non-waiver population in the population field, with Yes/No columns for each of the three 1915(c) waivers.
4. Assign CMHSP and PIHP for non-waiver and waiver payments based on the 820, 834, and 270/271.
5. Assign Spend-down eligibility indicator (Yes/No) using the 834 or 270/271.
    a. Milliman uses the field "HAS_BENEFIT_SPENDDOWN" from the 834.
    b. This will allow entities to identify GF dollars prior to spend-down for individuals that do not meet spend-down during the month.
6. Add columns for each member month to identify MI Health Link eligibility (enter the health plan or leave blank), Medicaid health plan eligibility (enter the health plan or leave blank), and the effective spend-down date (enter the date, or leave blank) using the COB loop of the 834 file.
7. Perform a full merge of the capitation and eligibility file by MemberID and month, further grouping each member month into one of the following categories:
    a. Medicaid eligible with capitation payment
        i. Members with a capitation payment that aren't in the underlying eligibility file should be considered eligible.
    b. Medicaid eligible without capitation payment
8. The merged file should still retain one record per member per month. The result of step 7 should include a culmination of the following fields:
    - Eligibility fields
        - MemberID
        - Incurred Month
        - Program (eligibility based)
        - Population (eligibility based)
        - CWP 1915(c) eligibility (Yes/No)
        - HSW 1915(c) eligibility (Yes/No)
        - SED 1915(c) eligibility (Yes/No)
        - Eligibility PIHP
        - Eligibility Spend-down (Yes/No)
        - MI Health Link health plan (health plan name or blank) – this field should be included to facilitate FSR expenditure reporting for the MI Health Link program Medicaid expenditures
        - Medicaid health plan (health plan name or blank) – this field is not needed in this template but may be used to identify the MHP Enrolled/Unenrolled split in future reporting
        - Spend-down effective date
    - Capitation fields
        - Program (capitation based)
        - Population (capitation based)
        - Non-waiver payment flag (Yes/No)
        - CWP 1915(c) waiver payment flag (Yes/No)
        - HSW 1915(c) waiver payment flag (Yes/No)
        - SED 1915(c) waiver payment flag (Yes/No)
        - Non-waiver capitation revenue
        - 1915(c) Waiver capitation revenue
        - Non-waiver capitation PIHP
        - 1915(c) capitation PIHP
9. The final step of the master eligibility file creation is to create one field for program, population, and each 1915(c) eligibility field. Priority should be given to the fields from the capitation file. If the capitation file does not have a valid program or population field (or if it is missing), then the program and population field from the eligibility file should be utilized. The capitation component of the 1915(c) eligibility field is based on whether or not an individual received a capitation payment.

10. The final master eligibility file should include the following fields in addition to the fields initially derived from the capitation and eligibility files:
    a. Eligibility type: Medicaid eligible with capitation payment or Medicaid eligible without capitation payment
    b. Program
    c. Population
    d. CWP 1915(c) (Yes/No)
    e. HSW 1915(c) (Yes/No)
    f. SED 1915(c) (Yes/No)
    g. Non-waiver PIHP (use eligibility PIHP if no capitation payment)
    h. 1915(c) PIHP (use eligibility PIHP if no capitation payment)

Incorporation of Master Eligibility File into Encounters

11. Merge Medicaid program, population, 1915(c) waiver eligibility flags, MI Health Link health plan, and spend-down effective date (if applicable) onto the encounter data. In general, the program and population used to summarize the encounter data for purposes of the EQI will be correct. However, **the following overrides should be considered and reflected on the *Service UNC* tab**:
    a. Services identified as Medicaid 1915(c) Waiver eligible
        i. If a member has 1915(c) waiver eligibility and the encounter is an applicable 1915(c) waiver service (for that same 1915(c) waiver, as identified in the service code sets), then override the population assigned to be the appropriate 1915(c) waiver population (HSW, CWP, or SED).
    b. Services incurred prior to spend-down effective date
        i. Determine within encounter data whether claims occur before the associated spend-down date, or on or after the spend-down date
            1. This date reflects the day they become Medicaid eligible. Using the daily 834 eligibility file (5997), users can identify the effective Medicaid eligibility date for spend-down beneficiaries.
        ii. The program and population assigned to services with an incurred date prior to the spend-down (Medicaid eligibility) effective date should be assigned as program = “Non-Managed Care” and population = “General Fund”.
        iii. If the spend-down date intersects a claim, for example an inpatient stay, break the claim into the spend-down portion and the Medicaid portion.
            1. This can be done by duplicating the claim and splitting the utilization and paid amounts proportionately by day.

12. Based on discussions with the EQI workgroup, the following overrides may be necessary for encounters reflecting Medicaid services provided to Medicaid beneficiaries but covered by other funding sources (i.e., they were identified as Medicaid using the logic described above and reported as such on the *Service UNC* tab, but they were not funded by Medicaid). These units and expenditures should be reported based on the logic above in the Service UNC, and then the funding source can be adjusted on the *Financial Reconciliation* tab using the following overrides. These override reconciling items will net zero expenditures between all fund sources as this reconciliation illustrates a shift of funds.
    a. Fund source overrides due to services provided in jail
    b. Fund source overrides due to other reasons
        i. Example 1. To follow Medicaid billing rules and other federal regulations should be input as *General Fund expenditures for services not billable due to an exception*
            1. CMHSPs have stated that several fund source overrides have historically been made to comply with Medicaid billing rules. One reason for overrides is that Medicaid cannot pay for services when the primary payer billing rules are not followed. An example of this is Medicare does not pay for certain services rendered by Licensed Professional Counselors (LPCs). Therefore, Medicaid and Medicare dual eligible beneficiaries receiving certain services from an LPC will require an override.
        ii. Example 2. Grant identification
            1. Services that are only partially paid for by grants should retain the program and population assigned from the eligibility file, with expenditures shifting from

Medicaid or General Fund to the Grant (i.e., Other) fund source using the *Expenditures for services covered by Grant Funding* reconciling item on the *Financial Reconciliation* tab.

III. Coordination between CMHSP and Regional PIHP

A certain degree of coordination will be required between the Regional PIHP and each of the CMHSPs within that region throughout the process of populating the EQI template. This section of the report details some of the anticipated coordination that will be required, by applicable tab within the template.

Service Cat UNC tabs

PIHPs can paste in each of the CMHSP values from each respective *Service Cat UNC – CMHSP* tab after validating the Medicaid information. General Fund and Grant utilization input on this tab for CMHSP rows will be ignored in PIHP totals. Regional PIHP units and expenditures from CMHSPs outside of their catchment area should be reported under the "Services contracted through PIHP" rows of the *Service UNC* tab.

Other Expenses

For the Medicaid and HMP expense category rows, the PIHP should summarize the applicable information reported from each CMHSP and then add in any additional Other Expenses incurred by the PIHP outside of the CMHSP contracts. Any additional Other Expenses incurred by the PIHP outside of the CMHSP contracts should be included in the Other fund source column of the *Other Expense* tab.

IV. Methodology and Instructions

The following sections provide the methodology and instructions for completing each of the tabs included in the template and information on the detailed encounters data extract.

Attestation

The purpose of this tab is to provide a CMHSP/PIHP representative attestation that the information submitted in the tool is current, complete, accurate, and in compliance with 42 CFR § 438.8 and 2 CFR § 200. It should be signed by a representative of the CMHSP/PIHP that is familiar with the information being reported and has the authority to make the attestation (for example, the Chief Executive Officer or Chief Financial Officer). It should also include the contact information of the individual(s) responsible for preparing the tool as submitted.

Service Code Set

This tab is intended to only be a reference and does not require any user input. It includes a listing of all possible service code combinations for the applicable revenue codes, procedure codes, and modifiers. This tab includes the following information:

- Index and service code index – this tab includes an index, but the primary lookup key that should be used is the service code index, as it will better facilitate comparison across multiple years in the future.
- Service codes – the possible HCPCS code, modifier, hospital type, and revenue code combinations are provided
- Service category and service category detail – the service categories reflect how the services are grouped for purposes of capitation rate development
- Service descriptions – the service description and reporting code description provide further information about each service
- Reporting units – the reporting units reflect the unit type of each service
- MH, SUD, or CCBHC – this column represents which benefit the service will be allocated to for purposes of capitation rate development. Note, If a claim line is has a CCBHC service code, has a T1040 on the claim, and was provided by a CCBHC (based on billing NPI) then it is marked as a CCBHC claim.
- Qualifying coverages – these columns represent the Medicaid authority for which MDHHS has received CMS approval. If all coverages are identified as “No”, then there is no Medicaid authority, and the service is either covered via Grants or state General Fund.

Eligibility and Revenue (PIHP Only)

The purpose of this tab is to collect the eligibility and revenue data for Michigan’s behavioral health managed care program. Eligibility and revenue should be attributed to the Medicaid managed care programs and populations using the logic above. We have included two columns to capture the attributed eligibility, a column for capitation payments and another to capture member months for those who are *Retroactively Eligible* for Medicaid. Please note that the PIHPs do not receive any capitation payments and corresponding revenue directly attributed to these retroactively eligible months. These individuals would be identified in Step 10 of the master eligibility file creation with an Eligibility Type of *Medicaid eligible without capitation payment*. We request that the PIHPs report the following revenue separately for individuals who received a capitation payment:

- Capitation Revenue (excluding insurance provider assessment (IPA) and hospital reimbursement assessment (HRA))
- Withhold Earned/Estimated to Receive
- IPA and HRA Revenue
- CCBHC Supplemental Revenue
- Other Revenue

We have also included rows to capture the number of capitation payments and associated revenue attributable to DHIP (identified as MCO_Program_Code = ‘0030’), Opioid Health Homes (HHO) (identified as MCO_Program_Code = ‘0027’), and Behavioral Health Homes (HHBH) (identified as MCO_Program_Code = ‘0076’).

Service UNC

The purpose of this tab is to capture the utilization and net expenditures for each service code, program, and population combination. The *Service Code Set* tab includes a listing of all possible services and the qualifying coverages (state plan, 1915(i), HSW, etc.). Based on the qualifying coverages, programs, and populations, we created a full listing of the possible codes for each population. We have also included an elig/service source based on the qualifying coverages, programs, and populations. We have included rows for the 1915(c) waiver populations for all services that are eligible under one of the 1915(c) waiver authorities, regardless of whether the service is considered a Medicaid service broadly to all beneficiaries. Managed care and non-Managed Care populations may receive Medicaid or non-Medicaid eligible services. If a beneficiary receives a 1915(c) Waiver service and they have 1915(c) Waiver eligibility (regardless of the scope and coverage codes of their Medicaid eligibility) for the respective service, then the units and corresponding expenditures should be reported on the applicable 1915(c) waiver population row on the Service UNC (e.g., HSW services provided to HSW enrollees that are Medicaid eligible as HMP should be reported on the applicable HSW population row). We also have provided lines for reporting of costs for services related to mental health, substance use disorder, and the Section 223 Certified Community Behavioral Health Clinic (CCBHC) Demonstration. MH and SUD services will be identified using member ID type 88/89 and the CCBHC services are identified by having a T1040 claim line.

The CMHSP/PIHP should report the utilization for each service code, program, and population combination included in the template. Section II describes the creation of the master eligibility file logic and merging of the eligibility and encounter data. The following provides the steps needed in addition to those to assign an encounter claim to the applicable row on the *Service UNC* tab:

1. Create the Service Code Index on the encounter claim file, which includes a combination of hospital type, revenue codes, procedure codes, modifiers (in that order). Reference B includes a crosswalk of the possible modifier combinations to the unique modifier combination used within the EQI template.
2. Identify whether the service is a CMHSP Direct-Run or Contracted through a Network Provider. For CCBHC rows, Designated Collaborating Organization (DCO) units and corresponding expenses should be reported under the Network Provider column. We will be identifying a CMHSP Direct-Run service if the Billing Provider NPI is the CMHSP for non-CCBHC encounters. Reference C provides list of NPIs that are classified as Direct-Run for each CMHSP.
3. Summarize units from the encounter claim file by the Service Code Index, Program, Population, MH/SUD/CCBHC, and whether the service is CMHSP Direct-Run or a Contracted through a Network Provider.

The *Service UNC* tab holds several rows with an Elig/Fund Source of “Non-Medicaid” and a Program of “Medicaid”. In these instances, the Elig/Fund Source indicates that the service is not covered by Medicaid because it is not a Medicaid service. For example, 92627 is listed in the *Service Code Set* tab as not having State Plan coverage or 1915(i) coverage, meaning it is not a Medicaid service (except for 1915(c) CWP enrollees). However, the Program of eligibility for the individual receiving this service can still be “Medicaid” under the DAB or TANF populations.

Utilization and net expenditures should be reported for services provided by a CMHSP separately from other services contracted through a mental health and substance abuse network provider. For CCBHC services, the contracted network provider columns should be leveraged for DCO service utilization and cost.

Total expenses attributable to grants should be reflected in one of the following areas for CMHSPs:

- Other population rows of the *Service UNC* tab (if covering the full cost of the service)
- Other population rows of the *Non-Benefit Expenses* tab
- Other fund source column of the *Other Expense* tab
- Other fund source column of the *Financial Reconciliation* tab for the row entitled *Expenditures for services covered by Grant Funding*

The CMHSP and dual CMHSP/PIHP template includes all the managed care populations as well as rows for general fund and other fund sources. The regional PIHP only includes rows for services contracted through the PIHP (other than the CMHSP) for all Medicaid managed care and Other fund sources.

There are both Medicaid and Medicare covered behavioral health services for MI Health Link program enrollees who are dually eligible under the behavioral health program.

Behavioral health services only covered by Medicaid should be reported to MDHHS under the behavioral health program on the *Service UNC* tab, including the full cost of the service on the encounter. Behavioral health services covered by Medicare should be handled using the following approach:

- PIHPs should only report claims reimbursed by the ICO for Medicare service to the ICO and not to MDHHS.
- If the Medicare reimbursement does not sufficiently cover the full cost of the service, the PIHPs should report an encounter under the behavioral health program to MDHHS, including the Medicaid paid amount and the Medicare coordination of benefits amount, consistent with other dual eligible beneficiaries.

TOTAL UNITS AND COSTS FOR ALL SERVICES

A. Enter the number of units per procedure code that were provided during the period of this report for beneficiaries with mental illness, serious emotional disturbance, developmental disabilities, and substance use disorders for each program and population. For most of the procedure codes, the total number of units should be consistent with the number of units for that procedure code that were reported to the MDHHS warehouse for all consumers. Follow the same rules for reporting units in this report that are followed for reporting encounters. Refer to the *SFY 2023 Behavioral Health Code Charts and Provider Qualifications.xlsx*[2] and the Behavioral Health and Intellectual and Developmental Disability Supports Chapter of the Medicaid Provider Manual[3] for additional reporting rules.

B. We have not separately identified services covered under the state plan, early periodic screening, diagnosis, and treatment (EPSDT), or 1915(i) benefits. All units and expenditures, net of COB, should be reported in the applicable CMHSP Direct-Run or Contracted Provider column. Please note that non-Managed Care beneficiaries may receive services defined as Medicaid eligible. These services are captured on the *Service UNC* tab and identified with a non-Medicaid "Elig/Service Source" but will be excluded from the Medicaid managed care program capitation rate development. All 1915(c) Waiver service units are to be reported on the *Service UNC* tab on the applicable 1915(c) Waiver population rows. Lastly, all non-Managed Care service units are to be reported on the applicable rows of the *Service UNC* tab under the applicable population line. Like above, Medicaid beneficiaries may receive non-Medicaid services that are not covered under the managed care capitation rates but are included for completeness.

C. Both inpatient service provider types, IMDs and local psychiatric hospitals, are separated out to distinguish between costs with **bundled per diems and those with the physician costs excluded**.

D. Community inpatient and IMD services reported should **not** include the estimate of the use (days) for incurred but not reported (IBNR) accruals for the current year. Similarly, all other services should not include estimates of the use for IBNR accruals for the current year.

   CMHSPs and PIHPs should report IBNR costs on the *Other Expenses* tab. There are three rows to report IBNR costs (for PT68, PT73, and all other services) incurred in the reporting year but for which there has not been an adjudicated claim at the time the EQI report is compiled.

E. Inpatient units should include services that were provided during the reporting period but funded by prior year savings or carry-forward or by funds pulled out of the ISFs.

F. Inpatient units should not include accruals or adjustments for services provided in previous years.

G. There are several rows to report Hospital Reimbursement Adjustment (HRA) expenditures on the *Non-Benefit Expenses* tab. The HRA expenditures should **not** be included on the *Service UNC* tab. Report HRA expenditures separately for population and program, including HRA corresponding to both institutions for mental disease (IMDs) (PT68) and for community inpatient (PT73). Since HRA is available only at the Medicaid level, payments should be split between DAB and TANF based on the proportional expenditures reported in the *Service UNC* tab. The sum of these amounts reported on the *Non-Benefit Expenses* tab should reconcile with the applicable FSR row.

H. Peer-support specialist services (H0038), Substance Abuse Peer Services (H0038SUD rows), Developmental Disabilities Peer Mentor (H0046), and Drop-in centers (H0023), each have a row to report

[2] https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html

[3] https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42553-87572--,00.html

units and costs for those services reported as encounters. In addition, there is a row on the *Other Expenses* tab for peer-delivered expenditures and drop-in center activities that were not captured by encounter data (i.e., the row entitled "Services not reported as encounters/Drop-in centers"). It is important that the appropriate numbers are entered in the correct rows for these procedures for different types of peers. Do not aggregate the units into one row.

I. Several codes have rows without modifiers as well as rows with modifiers: for example, 90849 (UN modifier used to distinguish when 2 patients are served), H0031 (WY modifier used to determine whether the assessment is a Supports Intensity Scale (SIS) assessment). It is important that the appropriate number of units and costs are entered in the correct rows for these procedures. Do not aggregate the units for the modified procedures into one row.

J. Enter the total net expenditures for each procedure code on the *Service UNC* tab under the applicable row for each population (see exclusions below). We have included all applicable procedure codes for each non-Waiver population. We have also included a row for each 1915(c) Waiver service and population combination.

K. The net cost per unit will be automatically calculated by dividing the net expenditures by the total units.

L. Rows for substance abuse procedure codes are included in the CMHSP template. If the CMHSP is providing these services or contracting with a provider for these services, then the number of units and total net costs should be included. If a PIHP is sub-capitating with a CMHSP for SUD services and the CMHSP is then contracting with other providers, the CMHSP should be reporting these units and expenditures in the *Service UNC* tab. CMHSPs should not include units and costs for services where the PIHP is contracting with SUD providers.

M. Please review the maximum allowable units included in the code charts on the MDHHS website to ensure that you are not reporting units above the allowable threshold[4].

N. The units tied to the following expenditures **must be excluded** from the *Service UNC* tab:
   a. Local contribution to Medicaid
   b. Room and board (except for expenditures reported under S9976)
   c. Payments made into internal service funds (ISFs) or risk pools. These payments must not be incorporated into allowable amounts either. The actuary will use the ISF reports submitted with the final FSR to identify use of fiscal year Medicaid revenues for funding of ISF.
   d. Provider of administrative service organization (ASO) services to other entities, including PIHP/hub ASO activities provided to CMHSP affiliates/spokes for non-Medicaid services.
   e. Write-offs for prior years.
   f. Workshop production costs (these costs should be offset by income for the products).
   g. Services provided in the state hospitals and Center for Forensic Psychiatry.
   h. Mental health services delivered by CMHSP but paid for by health plan (MHP or ICO) contracts.
   i. Medicare payments for inpatient days (where CMHSP has no financial responsibility).

ADDITIONAL NOTES FOR NON-MEDICAID SERVICES

A. The service line for reporting cases, units, and costs for State Psychiatric Hospitals was retired in SFY 2016. Local dollars for state psychiatric inpatient are to be reported on the *Other Expenses* tab.

B. The service line for reporting cases, units, and costs for Intermediate Care Facilities for Intellectual and Development Disability (ICF/MR) was retired in SFY16.

C. If room and board is reported as encounters (S9976) to the warehouse, enter the units and costs on the *applicable row of the Service UNC* tab. If room and board was not reported as encounters, report it on the *Other Expenses* tab.

[4] https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html

D. A row for All Pharmacy (ServiceCodeIndex = AggJCodes) is included on the *Service UNC* tab to report drugs, including injectables, and other biologicals. Do not report "enhanced pharmacy" units and costs in this row, but rather under T1999.

E. Any procedure codes that are not included in the template should be reported in the *Notes* tab. These are typically additional activities provided to individual consumers for which CMHSPs use general funds.

Service Cat UNC - CMHSP

This tab summarizes the data submitted into the *Service UNC* tab at the service category level. The CMHSP and dual CMHSP/PIHP template includes all the managed care populations as well as rows for Other and general fund services. The CMHSP and dual CMHSP/PIHP template does not require any input in the *Service Cat UNC – CMHSP* tab because it is automatically calculated. This information is intended to be incorporated by the regional PIHPs into their respective EQI template (i.e., the regional PIHP copies values from the *Service Cat UNC – CMHSP* tab of each CMHSP template and pastes them into the *Service Cat UNC – CMHSP* tab of the PIHP template under the corresponding rows of that CMHSP.

We have identified that the CMHSP health home expenditures were previously not identifiable on the *Service Cat UNC – CMHSP* tab. We have modified the Service UNC in Period 2 to address this issue by creating a *Health Home* Service Category). The Period 1 template included rows in the *Service Cat UNC – CMHSP* tab in which the "MH/SUD/CCBHC" column was "Health Home". These additional rows no longer exist given the new *Health Home* service category.

Service Cat UNC - PIHP

The regional PIHP template includes a second version of the *Service Cat UNC* tab that summarizes data submitted for services contracted through the PIHP. This *Service Cat UNC – PIHP* tab is automatically calculated and does not require any input.

Elig Source Summary - CMHSP

This tab is only on the CMHSP and Dual CMHSP/PIHP templates. This tab summarizes the data submitted into the *Service UNC* tab by Eligibility/Service Source, Program, Population and CCBHC vs. Non-CCBHC. The first table summarizes all non-health home (S0280) services, while the bottom table shows the summary of health home services only. The summary columns correspond exactly with what is on the *Service UNC* tabs. No input is required for this tab, as all information is automatically calculated for reconciliation purposes.

Elig Source Summary - PIHP

This tab is only on the PIHP templates. This tab summarizes the data submitted into the *Service UNC* tab and the *Service Cat UNC – CMHSP* tab by Eligibility/Service Source, Program, Population and CCBHC vs. Non-CCBHC. The first table summarizes all non-health home (S0280) services, while the bottom table shows the summary of health home services only. The summary columns correspond exactly with what is on the *Service UNC* tabs. No input is required for this tab, as all information is automatically calculated for reconciliation purposes.

Final Direct-Run Clinical Cost Center Summary (CMHSP and Dual CMHSP/PIHP Only)

This tab is optional to complete in SFY 2023 but will be required in future years for all CMHSPs. It is meant to be copied and pasted directly from the *Standard Cost Allocation Tool* tab of the same name. If the CMHSP is not utilizing the SCA tool, this tab should be filled out using the tool or methodology that the CMHSP is using to comply with MDHHS' SCA requirements.

COB Summary

The purpose of this tab is for the user to allocate the coordination of benefits input on the *Service UNC* tab to the various payers by program/population (Medicaid, HMP, General Fund, and Other). We have included common payers and have also allowed for users to attribute COB revenue to additional payers for both direct-run and contracted expenditures. The COB entries are meant to reflect net costs, so the COB payments should be reduced by any write

offs to reflect the total net costs. A row has also been included to capture any incurred but not reported (IBNR) COB revenue that is expected to be collected. We also have split this tab by CCBHC and Non-CCBHC expenditures.

Reporting of PA 423 Transferred Funds

Due to ongoing discussions for COB reporting, service level expenditures are to be reported on a net cost basis. With expenditures being reported on a net cost basis, reporting of PA 423 transferred funds has been moved to a reconciling item within the *Financial Reconciliation* tab and is no longer included on the *COB Summary* tab.

Non-Benefit Expenses

The purpose of this tab is to capture non-benefit expenses attributable to the behavioral health services. For purposes of this template, non-benefit expenses are being defined consistently with CMS' medical loss ratio (MLR) definitions for administrative costs as defined in 42 CFR § 438.8. The intent is that the information collected in this template is at the same level of detail required for the CMS MLR template required annually. MDHHS will be providing a separate template for completion to meet that federal requirement. Additionally, the CMHSPs may be incurring non-benefit expenses for the non-Managed Care population that has previously been included in the unit cost to deliver services.

Non-benefit expenses encompass the following components:

- **Non-claims costs** – Non-claims costs means those expenses for administrative services that are not: Incurred claims (as defined in paragraph (2) of 42 CFR § 438.8); expenditures on activities that improve health care quality (as defined in paragraph (e)(3) of 42 CFR § 438.8); or licensing and regulatory fees, or Federal and State taxes (as defined in paragraph (f)(2) of 42 CFR § 438.8). The following must be excluded from incurred claims and are considered non-claims costs under subsection (e)(2)(v)(A) of 42 CFR § 438.8:
    - (1) Amounts paid to third party vendors for secondary network savings.
    - (2) Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management.
    - (3) Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in § 438.3(e) and provided to an enrollee.
    - (4) Fines and penalties assessed by regulatory authorities.
- **Expenditures on activities that improve health care quality** – Activities that improve health care quality must be in one of the following categories:
    - (i) An MCO, PIHP, or PAHP activity that meets the requirements of 45 CFR 158.150(b) and is not excluded under 45 CFR 158.150(c).
    - (ii) An MCO, PIHP, or PAHP activity related to any EQR-related activity as described in § 438.358(b) and (c).
    - (iii) Any MCO, PIHP, or PAHP expenditure that is related to Health Information Technology and meaningful use, meets the requirements placed on issuers found in 45 CFR 158.151, and is not considered incurred claims, as defined in paragraph (e)(2) of this section.
- **Federal, State, and local taxes and licensing and regulatory fees** – Taxes, licensing and regulatory fees for the MLR reporting year include:
    - (i) Statutory assessments to defray the operating expenses of any State or Federal department.
    - (ii) Examination fees in lieu of premium taxes as specified by State law.
    - (iii) Federal taxes and assessments allocated to MCOs, PIHPs, and PAHPs, excluding Federal income taxes on investment income and capital gains and Federal employment taxes.
    - (iv) State and local taxes and assessments including:
        - (A) Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State or locality directly.
        - (B) Guaranty fund assessments.
        - (C) Assessments of State or locality industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.
        - (D) State or locality income, excise, and business taxes other than premium taxes and State employment and similar taxes and assessments.

        - (E) State or locality premium taxes plus State or locality taxes based on reserves, if in lieu of premium taxes.
    - (v) Payments made by an MCO, PIHP, or PAHP that are otherwise exempt from Federal income taxes, for community benefit expenditures as defined in 45 CFR 158.162(c), limited to the highest of either:
    - (A) Three percent of earned premium; or
    - (B) The highest premium tax rate in the State for which the report is being submitted, multiplied by the MCO's, PIHP's, or PAHP's earned premium in the State.
- **Fraud prevention activities** – MCO, PIHP, or PAHP expenditures on activities related to fraud prevention as adopted for the private market at 45 CFR part 158. Expenditures under this paragraph must not include expenses for fraud reduction efforts in paragraph (e)(2)(iii)(B) of 42 CFR § 438.8.
- **Hospital Reimbursement Adjustment (HRA)** - MDHHS maintains a hospital rate adjustment (HRA) program, which increases funding to hospitals for inpatient psychiatric treatment. The goal of the HRA is to sustain community psychiatric inpatient capacity and remove Medicaid access barriers. The HRA expenditures by should **not** be included on the *Service UNC* tab. Report HRA expenditures separately for population and program, including HRA corresponding to both institutions for mental disease (IMDs) (PT68) and for community inpatient (PT73). Since HRA is available only at the Medicaid level, payments should be split between DAB and TANF based on the proportional expenditures reported in the *Service UNC* tab.

Within the template, non-benefit expenses are broken out into delegated and retained expenses. Both PIHPs and CMHSPs may have retained administrative costs to the extent that they are incurring non-benefit expenses within their organization. Delegated expenses would be any non-benefit expense that is passed directly to CMHSPs by the PIHPs or to other subcontractors by the CMHSPs. PIHP delegated expenses should be equal to the sum of both retained and delegated non-benefit expenses reported by the CMHSP within their PIHP catchment area plus any other subcontractor non-benefit expenses. Both retained and delegated expenses can be transferred to the CCBHC columns of the *Financial Reconciliation* tab by using the Reconciling Items rows included.

Other Expenses

The purpose of this tab is to capture other expenses that cannot be attributable directly to an individual service but are being incurred to fulfill responsibilities the CMHSP or PIHP is required to do in their contract with MDHHS. **These expenses should not be duplicative of any expenses reported on the *Service UNC* tab**. This tab includes a description for each allowable other expense as well as the expense category it is anticipated to be attributed to. To the extent that there are other expenses that are not identified in this list that have been incurred by your organization, please include these on the *Notes* tab. The following list provides the expenses that may be incurred by a PIHP or CMHSP. Many of these items are only included and applicable for CMHSP entities.

A. Incurred but not reported (IBNR) expenses
B. Services not reported as encounters/Drop-in centers
C. Third Party Liability (Coordination of Benefits) Recoveries not reflected as reduced paid claims
D. Overpayments Recoveries Received from Network Providers
E. Incentives, Bonuses, Withholds, and Other Settlements Paid to Providers
F. Total Fraud Recoveries that Reduced Paid Claims (specify in notes if reductions aren't reflected in Service Cost)
G. Provider stability expenses not associated with service utilization
H. Behavioral health home (BHH) and opioid health home (OHH) service expenditures and administrative expenditures (Note: these health home service expenditures are not included on the *Service UNC* tab). Administrative health home expenses should correspond to the 20% of health home revenues retained by the PIHP.
I. Michigan Rehabilitation Services (MRS), MRS Cash Match
J. PASARR (not reported as encounter or claim)
K. Other Grant expenses associated with MH grants
L. Room & Board (not reported in S9976) funded by grants or general funds
M. Laboratory Procedures
N. Local Match for State Psychiatric Inpatient
O. DHS Worker for eligibility determination

P. Transportation (not reported as encounter or claim)
Q. Prior year adjustments
R. Jail Treatment Services - Not Embedded in General Fund Service Cost
S. Mental Health Code Functions, separately for Medicaid and General Fund
    a. Jail Diversion
    b. Recipient Rights Process
    c. Other MH Code Functions (specify in notes)
T. Injectable Medications (not reported as encounter or claim)
U. General Fund expenditures on Supportive Innovation Grant
V. Other General Fund or Grant expenses for costs associated with services in which an encounter was not submitted
    a. The *Other Expenses* tab for both PIHP and CMHSP entities includes lines for both General Fund and Grant costs associated with encounterable services where an encounter was not submitted.
W. CCBHC Section 223 Demo Expenses not included on *Service UNC* tab
    a. Note, the *Financial Reconciliation* tab transfers these expenditures to the applicable "CCBHC" columns, despite being reported as Medicaid/HMP on this tab.

Spend-Down Summary

The purpose of this tab is to summarize the distribution of expenditures before and after the spend-down effective date. Expenditures for individuals who are spend-down eligible but do not meet their spend-down amount should be included in the 'Prior to Spend-Down Patient Pay/GF' column. The total Spend-Down expenditures reported on this tab should reflect the total expenditures attributable to individuals who are identified as Spend-Down based on the logic provided in *Section II. Master Eligibility File Logic.* These expenses will be duplicative of expenses reported on the *Service UNC* tabs and are for validation purposes only. Expenditures before the spend-down effective date should be included on the *Service UNC* tabs on the non-Managed Care Program rows for both beneficiaries that meet spend-down for the month and those that do not. These expenditures will also be reported on the 'Prior to Spend-Down Patient Pay/GF' column in the current tab. Expenditures incurred on or after the spend-down effective date should be included on the *Service UNC* tabs on a BH Managed Care Program row in addition to being reported on this tab by service category as 'Post Spend-Down Medicaid'. The service category for each service code index can be found in the Service Code Set. For a breakdown of the logic used to identify expenditures prior to and after the spend-down effective date, see *Section II. Master Eligibility File Logic*.

Financial Reconciliation

The purpose of this tab is to summarize all revenue and expenses from each of the tabs included in the reporting template for review. Additionally, it provides an area for the CMHSP/PIHP to include any Reconciliation Items that would otherwise prohibit the CMHSP/PIHP from reconciling with other MDHHS reporting requirements (e.g., FSR). The pre-determined reconciling items are as follows:

- PA 423 Transfer
- Payments (or Receipts) Related to ISF
- Expenditures for services covered by Grant Funding
- Expenditures for services covered by General Fund
- Jail Service Overrides
- Other Service Overrides
- CCBHC PPS vs Expense Adjustment
- Transportation reported and billed separately

Also note the regional PIHP templates separately identify CMHSP General Fund and Other expenditures reported on the *Service UNC* tab and exclude these expenditures from the *Grand Total PIHP Expenses*.

This tab has columns split out for CCBHC expenditures and revenue. For certain items, such as non-benefit expenses, the reconciling items section can be used to transfer expenses from Non-CCBHC columns to CCBHC columns. Additionally, this tab transfers the CCBHC Section 223 row from *Other Expenses – PIHP* tab from the Medicaid/HMP columns to the applicable CCBHC columns.

Additionally, health home is included on this tab, but is identified separately from all other items in each section. The purpose behind this decision is due to health home being excluded from the FSR comparison.

TIN Listings

The background of this tab is as follows: As outlined in Medicaid Policy 21-39[5], beginning in the SFY 2023 experience period MDHHS requires providers above a specific expenditure threshold to submit a Contracted Provider Expense Report. To support further review of the expenditure threshold and the Contracted Provider Service Expense Report, MDHHS is requiring that each PIHP complete this survey and provide the total expenditures at the Tax ID number level for each of their network providers. PIHPs must submit this information for any network provider across any/all fund sources, including but not limited to:

- Network providers
- Financial management services providers (formerly fiscal intermediaries)

Expenditures reflected on the *TIN Listings* tab should reflect the encounters included on the *Service UNC* tab. The expenditures may not align given CMHSPs/PIHPs can input expenditures from the data warehouse. **PIHPs should not incorporate CMHSP encounters within their *TIN Listing* unless the CMHSP is not reporting anything in their respective Tool.**

SFY 2023 reported expenditures at the Tax ID number level will be adjusted to reflect the expenditures reported on the *Service UNC* and will be used determine whether an entity is subject to the additional reporting requirement: *Contracted Behavioral Health Provider Service Expense Template.*

The instructions for filling out this tab are as follows:

Tax ID Number - enter the tax identification code for the network provider. If the network provider organization has multiple tax identification codes, please report each TIN on a separate row of the template with the same Organization Name. Each network provider organization should be reported on one row on the *TIN Listings* tab. The Tool will require Tax ID Numbers to be reported as 9 digits in the format of "xx-xxxxxxx", and it is requested that leading zeros be added to any TINs that are less than 9 digits.

Organization Name - enter the provider organization name (individual or group), using the TIN to Organization crosswalk that was provided to you by DHHS and posted on the MDHHS website (i.e., Grouped Organization Name). If the organization is not listed in the TIN to Organization crosswalk, please select "Yes" in the "New Organization" column.

Total Expenses - enter the total expenditures for SFY 2023. These expenses should reflect the encounters included on the *Service UNC* tab although the expenditures may not align given CMHSPs/PIHPs can input expenditures from the data warehouse. PIHPs should exclude expenditures associated with CMHSP contracted services for purposes of this tab.

Billing Provider NPI(s) - enter all the billing national provider identifiers (NPIs) for the network provider. If the network provider has multiple billing NPIs, please report all NPIs and separate each NPI with a semi-colon.

Medicaid Provider ID - enter the Medicaid provider identification code for the network provider. If the network provider has multiple Medicaid provider IDs, please report all IDs, and separate each ID with a semi-colon.

Residential CLS - enter if the provider is a residential community living support provider.

New Organization – enter "yes" if the organization is new in fiscal year 2023 or is not listed in the TIN to Organization Crosswalk.

Notes – for any notes that Milliman or DHHS should be aware of related to the line entry.

[5] https://www.michigan.gov/documents/mdhhs/MSA_21-39-BHDDA_739911_7.pdf

Notes

The purpose of this tab is to capture any additional notes that regarding the EQI submission that would be helpful to understand the information reported within the EQI template.

V. Detailed Encounter Extract

Beginning in SFY 2023, MDHHS has incorporated a detailed encounter data extract at the beginning of each EQI cycle to support CMHSPs and PIHPs with submitting complete and accurate EQI reports and encounter data. These extracts will be made available for each PIHP based on encounter data submitted by each PIHP into MDHHS' data warehouse consistent with the schedule outlined in Figure 1. Reference D contains a full list of fields in the detailed encounters extract. The following sections provide additional information on fields created by Milliman for this extract.

Paid

The following outlines how the paid field is created.

1. The paid field is determined either at a header or claim line detail level, indicated by the DollarFlag field (also included in data extract):
    a. For each claim line if Invoice_Type is not equal to "I" and HEADER_FROM_SVC_DATE and HEADER_TO_SVC_DATE are not the same month then DollarFlag is assigned "Line"
    b. If the header amount (described below) is not equal to 0 and the line amount (described below) equals 0 then DollarFlag is assigned "Header"
    c. For all other claim lines, DollarFlag is assigned "Line"
2. If DollarFlag equals "Header" then paid equals sum of HEADER_OTH_PAYER_COB_PAID_AMT and HEADER_OTH_PAYER_ADJ_AMT_X when HEADER_OTH_PAYER_ADJ_REASON_X equals "24" or "104"
    a. The Header amount is allocated to each claim line based on the proportion of the total billed amount
3. If DollarFlag equals "Line" then paid equals the sum of LINE_OTH_PAYER_PAID_AMT and LINE_OTH_PAYER_ADJ_AMT_X when LINE_OTH_PAYER_ADJ_REASON_X equals "24" or "104"

EQI Population

This field corresponds to "Population" in *Service UNC* tab of the EQI template and is calculated consistent with the population methodology described in the Mater Eligibility File Logic section.

Please note that Milliman does distinguish between "General Fund" and "Other" populations in the detailed encounters. These populations would make up the "Non-Medicaid" portion of the EQI Population field.

Program

This field corresponds to "Program" in *Service UNC* tab of the EQI template. The following outlines how the field is created.

1. If EQ Population is not "Non-Medicaid" or "HMP" then Program equals "Medicaid".
2. If EQI Population is "Non-Medicaid" then Program equals "Non-Managed Care".
3. If EQI Population is "HMP" then Program equals "HMP".

Elig_Service_Source

Elig_service_Source corresponds to "Elig/Service Source" column in *Service UNC* tab of the EQI template. The following outlines how the field is created.

1. If the Member is "Non-Medicaid", then it is equal to "Non-Medicaid"
2. If the service code and Member is CWP/SED/HSW eligible then Elig_Service_Source is "1915(c)".
3. Otherwise, if the encounter has a service code that is listed as not state plan or 1915(i) in the *Service Code Set* tab or the member is not Medicaid eligible then it is equal to "Non-Medicaid".
4. All other encounters are listed as "Medicaid".

Full_service_Code_EQI

This field corresponds to the Service Code Index on the *Service UNC* tab in the EQI template. It is calculated by matching the HCPCS, modifiers, revenue code, and/or hospital type on the encounter to a service code in the *Service Code Set* tab in the EQI template. Reference B contains a crosswalk of possible modifier combinations and how they will be mapped to the correct modifier order for reporting purposes.

Jail Flag

This field identifies services that were provided in a jail setting. Encounters with a "QJ" modifier or a FACILITY_TYPE_CODE of "09" are considered services provided in a jail setting. Please note that in the detailed encounters, jail services are not automatically considered non-Medicaid to align with the Service UNC expectations.

Override Reason

This field provides brief reason as to why an encounter is "Non-Managed Care" or "Non-Medicaid". For example, if the beneficiary of the claim does not have a matching eligibility or capitation record the claim is considered "Non-Managed Care" and the override reason is set to "No Eligibility record". Other reasons include the claim does not have a beneficiary with an eligible benefit plan or capitation payment. Please note that if the beneficiary has an eligible benefit plan or capitation payment they will be list as "BH Managed Care" and will have an override reason of "N/A".

VI. Limitations and Qualifications

The EQI Data Collection Tool and accompanying instructions have been prepared for the internal use of MDHHS along with the intended PIHP recipients. No portion may be provided to or relied upon by any other party without Milliman's prior written consent. Milliman does not intend to benefit or create a legal duty to any third-party recipient of its work. Likewise, third parties are instructed that they are to place no reliance upon this tool prepared for MDHHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

The EQI Data Collection Tool is subject to the terms and conditions of the signed contract between Milliman and MDHHS dated November 21, 2022.

Milliman has developed this tool to collect information that will assist MDHHS in calculation and assessment of the Medicaid Encounter Data. We have reviewed the tool, including its inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP). The tool relies on data and information to be input by the PIHPs. To the extent that the data and information provided in the tool is not accurate or is not complete, the resulting values may likewise by inaccurate or incomplete.

We perform a limited review of the data used directly in our analysis for reasonableness and consistency to identify material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Qualifications:
Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors/creators of the EQI Data Collection Tool and accompanying instructions are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses associated with this communication.

APPENDIX A - EQI FINANCIAL DATA REQUEST
(Provided Separately in Excel)

REFERENCE A – COUNTY CROSSWALK

REFERENCE B – MODIFIER CROSSWALK

REFERENCE C – DIRECT-RUN NPI LIST

REFERENCE D – DETAILED ENCOUNTERS FIELD REFERENCE